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Hearing on "Making Health Care Work for American Families: Saving Money, Saving Lives"

Chairman Pallone and Ranking Member Deal, thank you for the invitation to testify about improving health care value. My name is Christine Cassel, and I am a board certified internist and geriatrician and President and CEO of the American Board of Internal Medicine (ABIM) and ABIM Foundation.

ABIM – which certifies about a 1/3 of practicing physicians – is the largest of the 24 certifying boards that constitute the American Board of Medical Specialties (ABMS). The boards – all of which are independent non-profits that do not accept industry funding – were created to assure the public that physicians have the necessary knowledge and skills to practice in a given specialty. Collectively, the certifying boards' investment in enhancing quality is significant, totaling about $150 million per year. We are increasingly able to demonstrate through research that higher standards for physicians mean better quality care for patients.[1] Consequently, we believe that our standards should continue to be incorporated into and aligned with the accountability frameworks of both public and private payers.

I very much appreciate the Committee's leadership in examining the link between quality, cost and value in our health care system. Particularly in this challenging economy, unnecessary health care spending is burdensome to patients, families and businesses – as well as to government. Physicians feel this burden as well when patients cannot afford the care that we recommend for them. There is ample evidence of waste and unnecessary spending on overutilization of services in the U.S. health care system.[2] Unnecessary care can also be harmful to patients – every medication carries risks, every procedure has potential complications and every hospitalization exposes patients, especially the elderly and others who are vulnerable, to infections, falls and other harms.

My testimony today is intended to inform the Committee about three key points:

- Why it makes sense to target care for patients with multiple chronic conditions and those at the end of life in order to realize significant gains in quality and value for the nation's healthcare system;
- How innovations – such as patient centered medical homes and other models – can facilitate changes in medical practice and increase value provided they target high cost, high need populations and have built-in accountabilities; and
- The need to support highly-skilled generalists (such as primary care physicians and geriatricians), who are in short supply, so that they can effectively deliver on the promise that these models hold out to simultaneously save money and save lives.

The need to enhance care for those with chronic conditions and care at the end life is abundantly clear.

- Almost half of Americans have at least one chronic condition, and chronic diseases account for 70% of all deaths in the United States and one-third of the years of potential life lost before age 65. The problem is not a lack of spending on services: medical care costs for people with chronic diseases account for more than 75% of the $2 trillion our nation spends on medical care each year.[3] In too many cases, the problem is a failure to deliver the right care at the right time, and to coordinate complex care needs across multiple providers and settings in a patient-centered way. In fact, the Medicare Payment Advisory Commission (MedPAC) has estimated that Medicare could save $12 billion dollars per year through reducing unnecessary hospital readmissions, improving care transitions and care coordination and enhancing primary care.[4] Most important, if these changes were made patients would benefit with enhanced outcomes and higher satisfaction with their care.

- Palliative and end of life care are areas that could contribute to increasing value in our health care system since medical costs increase sharply for patients in the last two years of life.[5] Research shows clearly that when patients needs and values – rather than services – are the focus of care decisions, fewer resources are spent on fruitless care and patients and their families experience improved quality of life and mental health. One study found that patients with advanced cancer who reported end of life conversations with their doctors had lower medical costs in their final week of life compared with those who did not, which the

authors attribute to more limited use of ineffective, intensive interventions. Another study found an association with end of life discussions and both less aggressive technical interventions near death and earlier hospice referrals. The authors also found that aggressive care actually causes harm (in addition to increasing costs) – it was associated with worse patient quality of life and worse bereavement adjustment for family members.[6] In my experience as a geriatrician, I have seen how aggressive interventions have a way of stripping from a very sick patient the last vestiges of autonomy and control. When there really is no hope, it is a very sad exit from the world.

A number of models that could be used to improve care for patients with chronic conditions and those at the end of life are being developed and tested, including the patient-centered home model (PCMH), accountable care organizations (ACOs) and other innovations. I would like to focus my remarks on the medical home and other ambulatory focused models since my colleague Dr. Skinner will provide testimony on ACOs. I think medical homes have the potential to simultaneously reduce costs and improve quality, while promoting efficient office practice design, professional recognition and remuneration of primary care physicians and geriatricians who are needed to create, manage and lead such practices.

This Committee has likely heard the strong case for supporting more robust primary care:

- A Commonwealth Fund study comparing communities across the country found that the highest performing regions have fewer practicing physicians and are more reliant on primary care, are less likely to re-admit patients to hospitals, and, overall, use fewer hospital and intensive care services.[7]
- A multivariate analysis found that higher proportions of primary care physicians are independently associated with fewer hospital admissions, emergency department visits and total surgeries. This same study showed that a modest 1 percent increase in the proportion of primary care physicians in a region resulted in 3.83 fewer emergency department visits on average per 1,000 people in a given year.[8]

Rebuilding primary care has taken on new urgency as primary and geriatric care have become vanishing specialties. A study last year showed that only two percent of graduating medical students were planning careers in general internal medicine.[9] Given this reality, I would like to offer the Committee three ideas about how the PCMH and other ambulatory care focused models can make the best use of generalist

physician skills and simultaneously leverage the talent and experience of other types of clinicians.

First, services that primary care physicians provide should be targeted to the highest cost and highest need populations:

- Internal medicine, family physician and geriatrician specialists need to focus the majority of their time and talent on managing, coordinating and integrating the care of those with complex and multiple chronic conditions. They need a broad understanding of multiple specialties and organ systems in order to effectively manage the care of these patients.
- This means that other members of the clinical team will have an active role in prevention, wellness care and providing ongoing care to those with less complex chronic conditions.

Patients, particularly those with complex needs, will ideally have a longstanding relationship with their physician.

- The presence of a primary care physician – including a longstanding relationship – results in better care, less illness and death and more equitable distribution of health among various populations.[10]
- Medicare and private payers will need to figure out how to establish and nurture such relationships while recognizing patient desire for choice and the ability to "vote with their feet."

Primary care and geriatric physicians will need to be given the necessary tools – both accountabilities and incentives – to support coordination beyond the confines of primary care practices.

- In order to manage patient care across settings, physicians and other providers need to have much more robust information sharing and have in place accountabilities and related incentives to coordinate and integrate care,[11] for example, making payment to specialists contingent on the primary care physician receiving the specialist's consult notes.
- Referrals to specialists and tests is another area that needs better management. Many patients and payers are reluctant to return to a gatekeeper model, but there must be a way to connect all of the specialists a patient sees to ensure that there are not gaps, redundancies and contradictions in treatment. Unnecessary use of specialists and tests drive up U.S. costs as compared to the health systems of other industrialized nations.[12]

These ideas – targeting high need patients, supporting an ongoing relationship between patients and physicians, and attending to the role and accountabilities of physicians outside the medical home – need better incorporation into a model that to date has largely focused on practice infrastructure, for example, health information technology (HIT), and payment reform, in order to effectively reach our goals for enhanced quality and value.

Finally, I would like to suggest that board certification and maintenance of that certification through regular, formal skills testing, practice monitoring, and self-evaluation, offer ways to enhance the skills of physicians – both those who are in the midst of their training and those who are in practice – and to ensure that physicians can manage complex patients. Leading health plans have recognized this critical benchmarking and have put a premium on physicians who are involved in ongoing re-certification or maintenance of certification (MOC) in their reward and recognition programs. The certifying boards have also been involved in discussions with Senate staff to recognize MOC as a pathway within the Medicare PQRI program and we would ask the House leadership to give this idea the same consideration.

Very briefly, the kind of knowledge and skills assessed by board certification programs include:

- **Diagnostic acumen** – Research has shown that up to 15 percent of medical errors and 40,000 to 80,000 hospital deaths are attributable to faulty diagnoses.[13] Our current accountability frameworks, which are largely reliant on performance measures, assume that a correct diagnosis has been made;
- **Clinical knowledge/judgment** – Keeping up with the ever expanding medical knowledge base is critical for diagnosis and for determining treatment. Board tools assess a physician's ability to synthesize and incorporate new medical knowledge (this knowledge can also be augmented with important investments in comparative effective research);
- **Systems thinking and QI capability** – The investment in HIT via the stimulus package is critical for providing necessary infrastructure for physician practices to coordinate and integrate care. That said, the promise of such investment will only be realized if physicians understand how to incorporate HIT into their practices – both with respect to redesigning work processes and care delivery. Further, physicians need to understand how to change their practices based on the performance data that HIT will be able to provide;
- **Translation of knowledge into practice –** Finally, board certification programs assess whether physicians translate their

knowledge about practice in a given specialty into practice via tools that incorporate NQF performance measures – the same measures already integrated into existing reward and recognition programs. These board tools also require that physicians design and implement a QI intervention in response to an identified practice weakness.

Stronger infrastructure, better connectivity, and physician payment reform are essential elements of the PCMH. However, at the end of the day the quality of medical care for complex patients – indeed for all patients – rests on the skills and judgment of the physician in whose care the patient is entrusted. Board certification programs demonstrate and hold physicians accountable for the very skills that innovative care delivery models need to achieve the ultimate sweet spot of enhancing quality and value.

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